

End-of-life care: out of darkness, a new light

Cure sometimes, treat often and comfort always – Hippocrates

As clinicians, we are in a uniquely privileged position; we have passive admittance to the most private aspects of human life and often find ourselves silent observers of death. Sometimes we may be left feeling powerless and that maybe we have failed, given the expectations of modern medicine. In this issue of the *Future Healthcare Journal* we explore the complexities of creating sustainably resourced end-of-life and palliative care services. These require a foundation of specialist education and skills to empower clinicians, not only to recognise dying patients, but to actively embrace compassionate end-of-life treatment.

Serving as guest editors has been an exceedingly rewarding experience, giving us an opportunity to highlight the enormous amount of work occurring throughout the country, where clinicians are carefully and conscientiously improving the delivery of end-of-life care. Whether by creating new services, implementing new initiatives or restructuring existing resources, clinicians are increasingly being drawn upon to be inventive in a progressively financially constricted NHS. Such work includes the creation of inpatient palliative care units,¹ the identification of frail older patients in need of advanced care planning,² and developing models of care that enabling patients to die in their chosen setting.³ These are powerful initiatives, that focus on the individual patient, respect for their autonomy, their families and their choices in the design of their services.

The need for innovative and flexible palliative care services spanning hospital, hospice, community and home settings are clear. The articles in this issue of the *Future Healthcare Journal* demonstrate the ability to deliver high quality, evidenced-based end-of-life care that recognises patients approaching the end of life and enables shared decision making to meet individual patient needs. This shows the NHS can respond appropriately to the NICE guideline *Care of the dying adult in the last days of life* (NG31).⁴ Furthermore, these articles illustrate that a modern approach can facilitate a good death, meeting the requirements for the psychosocial and spiritual needs of patients at the end of life, in addition to addressing their physical concerns.

There are still challenges, however, as the controversial topic of assisted dying continues to be debated, and there may be a perceived disparity between the medical profession and the public.⁵ While there has undoubtedly been a shift in attitude in post-war Britain, the reality is that most clinicians strive to uphold the principle of *Primum non nocere* (do no harm) and therefore struggle with the ethical and moral implications of such acts.^{6,7} While this may be grounded in their moral, ethical and religious beliefs, it may in fact, be a product of the very values that inspire individuals to become doctors in the first place. ■

References

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